Kathy J Dube 5/28/09 Plan of Correction accepted

PRINTED: 05/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295043	A. BUILDING _____ B. WING _____	04/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	3101 PLUMAS RENO, NV 89509

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on 4/09/09 through 4/16/09. The census was 178 residents. The sample size was 24 current resident, 3 closed records and 5 unsampled residents. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes Manor Care Health Services allegation of compliance. The alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 155 SS=D	483.10(b)(4) NOTICE OF RIGHTS AND SERVICES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, patient and staff interview, the facility failed to provide written information to one of 27 sampled residents, regarding the formulation of an advance directive. (#11) Findings include: Resident #11 was readmitted to the facility on	F 155	F155 The facility does and will continue to provide written information regarding the right to formulate an advanced directive. • Resident # 11 has been offered the opportunity to formulate an advance directive and this offer has been documented in the medical record. • Residents admitted to the facility have the potential to be affected. The Social Worker will assist new admissions in formulating an advance directive and document their wishes. A chart audit was conducted and residents identified were offered the opportunity to clarify their wishes if they so desired.	4-16-09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Deborah Ryals | Administrator | 5/15/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA
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MAY 15 2009

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F 155	Continued From page 1 1/7/09 following an acute hospitalization. He had been a resident at this facility since January of 2007. Review of his current record revealed that he did not have any advance directives or Power of Attorney for Health care on record and Resident #11 was his own responsible party. The clinical record revealed that there were two children listed as contacts. The current admission record also revealed that although Resident #11 had been a full code during his previous admission, he was not able to confirm to the staff that that remained his desired wish. Review of the clinical record revealed that on 3/27/09, Resident #11 was interviewed by a social worker (Employee #5). At that time the social worker documented that Resident #11, "...explained he wanted to be a full code if there was an chance for one more breath, I want it. I'm not afraid to live." There was no evidence in the clinical record that the social worker offered Resident #11 the opportunity to formulate an advance directive, or to formally express his wishes. An interview with the social worker (Employee #5) on 4/10/09, revealed the social worker did not ask Resident #11 if he wanted to formulate an Advanced Directive because she felt uncomfortable discussing advanced directives with the resident. The social worker also confirmed that the resident did not ask to formulate any Advanced Directives, and she did not feel it was her responsibility to approach the subject. An interview with a second social worker	F 155	• Social Service staff have been re-educated to their responsibility to assist residents with formulating an advance directive as needed. • Random audits will be completed by Medical Records to ensure the system remains in compliance. Audit results will be reported to the Administrator and QAA committee on at least a quarterly basis.	5-26-09

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F 155	Continued From page 2 (Employee #12) on 4/14/09, revealed that it was the responsibility of the social services to meet the residents needs, including assisting with formulating advance directives. She also confirmed that the needs of the residents should be addressed without the resident having to ask for assistance when that need becomes known to the staff. An interview with Resident #11 at 9:00 AM on 4/14/09, revealed that he confirmed he wanted to be a full code.	F 155		
F 164 SS=B	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when	F 164	F 164 The facility does and will continue to provide confidentiality of medical records. • Cover sheets provided for each medication book for the licensed nurses to utilize when they are absent from the medication cart • Residents receiving medications have the potential to be affected and utilization of the cover sheet will protect the confidentiality of the medical record for these residents. • Transport staff and licensed nurses will be re-educated on confidentiality of the medical record • Compliance will be monitored during daily rounds by nurse managers. Noncompliance will be addressed immediately and trends reported to the Director of Nursing for further corrective action.	5-26-09

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F 164	Continued From page 3 release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of inservice records, the facility failed to provide adequate protection for and confidentiality of residents medical records. Findings include: During the medication pass on 400, 500 and 600 halls of the Kensington unit at approximately 8:30 AM on 4/13/09, it was noted that on two occasions, the transportation co-coordinator requested several residents' Medication Administration Records (MARS). When the medication nurse was asked what the transportation co-coordinator was doing with those records, she replied that he was copying the MARS for the residents that had physician's appointments outside of the facility. On both occasions when the medication nurse and myself returned to the medication cart, the MARS were found to be lying on top of the cart available to anyone who wished to read them. In an interview with the Assistant Director of Nurses on 4/14/09, she provided documentation that the Transportation Coordinator had been provided HIPPA training. She agreed that the MARS should have not been left on top of the medication cart without being covered. During the same medication pass, it was observed that on two occasions, the book	F 164		

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F 164	Continued From page 4 containing the residents' MARS was left open and the medication information was visible to all while the medication nurse was away from the cart. Observations during medication pass on 4/10/09 on Stratford hall, the Licensed Practical Nurse (LPN) did not cover the medication administration record for one of four residents when she left the medication cart. Random observations of the medication carts during the survey revealed that during a two hour period (8 AM -10 AM) on 4/15/09, a medication administration record book on Stratford hall was left open to individual resident medication records in five of six observations during that two hour period. An interview with the LPN (Employee #14) was conducted at 10:00 AM on 4/15/09. She confirmed the medication record was not covered at this time, although she had not been aware that she had not covered the medication records consistently. The LPN confirmed that the facility policy was to cover the medication record, to ensure privacy of the individual resident's medications and diagnoses.	F 164		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to promote care for a resident in a manner	F 241		

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F 241	Continued From page 5 and in an environment that maintained the residents' dignity and respect for 1 of 29 residents (#29). Findings include: On 4/15/09 at approximately 1:15 PM, Resident #29 indicated that this morning when staff were getting her and her roommate up for breakfast, one of the staff members (in the Resident #29's presence) had made a comment about her to her roommate. The resident indicated that the staff member had said to the roommate, "It's a shame they put a nice lady like you in with her, someone that's not very nice." The resident indicated that another staff member was present when the comment was made. When asked if the incident had been reported, the resident indicated she had not reported it. When this surveyor began to discuss Resident's Rights with the resident, the resident indicated she had previously been a defense lawyer and had no problem speaking up for her self, as this was being said, Licensed Practical Nurse (LPN) #11 came into the room to answer the call light, at which time the resident repeated her story to the LPN. LPN #11 was observed taking Resident #29's statement. The LPN explained to the resident that she was going to reassign nursing assistant #13 until an investigation was completed. The LPN indicated that she would notify the administrator and explained the facility's policy for any abuse or other related types of allegation. The LPN was then observed explaining to the resident her rights and the process for reporting incidents.	F 241	F 241 This facility does and will continue to treat residents with dignity and respect. • Resident # 29 states there has not been a reoccurrence of any similar incidence. • Any resident transferring units has the potential to be affected. • Both staff members were re-educated on dignity and respectful communication with residents and not speaking about a resident in his/her presence. Resident rights, including notification of concerns are reviewed upon admission and during monthly Resident council meetings. • Corrective action will be monitored utilizing monthly customer service surveys and monthly Resident Council Meetings. Problems identified will be reported to the Director of Nursing for corrective action.	5-14-09 5-26-09

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F 241	Continued From page 6 An interview with the LPN, revealed that the resident had been transferred to the Wellington Unit on 4/14/09. Review of Resident #29's Minimum Data Set (MDS) revealed that the resident, was independent in decision making, able to make her needs known. Note: On the morning of 4/16/09, an interview with the Administrator revealed that an investigation was initiated on 4/15/09.	F 241		
F 250 SS=E	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and observation, the facility failed to provide pertinent social services to 5 of 27 residents.(#2, #3, #14, #18, and #11) Findings include: Resident #2 had been admitted to the facility on 11/20/08. His diagnoses included right hemiplegia resulting from a cerebral vascular accident, dysphagia and depression. Record review revealed that the last documentation from social services was on 2/24/09. Several issues were indicated in the	F 250	F 250 The facility does and will continue to provide medically related social services to the residents. • Resident #2: Social Service review and intervention is on-going. Resident #3: Responsible party has been clarified Resident # 18: Is no longer at the facility Resident # 14: Discharge plans have been clarified and Social Service intervention is documented. Resident # 11: Has received assistance with advance directives.	5-14-09

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F 250	Continued From page 7 record; a petition for a guardianship, an appeal to a private insurance company for payment of incurred costs, a possible application for Medicaid, and the resident's apparent depression because of some of the issues. Note: The status of these concerns could not be determined from the social services records. In an interview with the Social Worker (Employee #5) on 4/10/09 at 2:45 PM, she revealed that the department had been short staffed and that she was probably lacking some current documentation. She was not aware of the status of the guardianship. She did disclose that the appeal to the insurance company had been denied and that she had been advised by a Medicaid caseworker to delay an application for Medicaid. None of these information was documented in Resident #2's record. There was also no evidence that the social worker had been providing any support or counseling to assist the resident in dealing with his depression. Resident #3 had been in the facility since 1/23/09. Her diagnoses included anoxic brain damage and debility. She had, previously, suffered a cardiac arrest and a perforated esophagus during surgery. As a result of the perforation, she had a feeding tube, but was doing well with oral feedings. The resident record contained a Power of Attorney listing her son as the responsible party. Social Services information contained conflicting information as to who was the responsible person, having notified the resident's sister first on occasion for a decision. Some of the record identified the sister as the resident's daughter.	F 250	• Residents discharge goal will be identified within 7 days after admission and actions toward achieving the goal documented in the medical record. Residents continued need for long term care is assessed and documented at the time of quarterly review. Resident responsible party information is identified on admission and noted on the face sheet and validated at the time of the quarterly review. Residents are advised of the right to formulate an advance directive upon admission. Assistance to formulate an advance directive is provided at the resident's request. Advance directives and or end of life wishes are validated at the time of the quarterly review and documented. • Social Services process and documentations systems were reviewed. Social service staff were re-educated to federal and state requirements. • Random audit for compliance with the process and documentation requirements will be on-going. Discrepancies, if any, will be addressed immediately, trends, if any, will be identified and forwarded to the QAA committee for action and resolution at least quarterly. The Administrator is responsible to ensure compliance.	S-26-09 S-26-09

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F 250	Continued From page 8 Resident #18 had been admitted to the facility on 3/30/09, as a short term admission for rehabilitation. She had spinal surgery prior to her admission. In addition, she had insulin dependent diabetes, congestive heart failure and coronary artery disease. She planned to return home to reside with her spouse. She was discharged on 4/16/09. Review of the record revealed only the admission documentation and the actual discharge. There was no evidence of any active ongoing discharge planning. The section on Discharge Planning Services from the Manor Care Social Services Manuel Guidelines stated, "The social worker initiates the discharge planning services at the time of the admission by ascertaining the resident's anticipated length of stay. The anticipated length of stay determines the urgency necessary to produce the desired results during the pre-discharge phrase." Resident #14 had been at the facility since 1/24/09. Diagnoses included insulin dependent diabetes mellitus, pleural effusion, congestive heart failure and coronary artery disease. Documentation from the physician in the progress notes indicated various concerns that might preclude Resident #14 from returning home, such as poor safety awareness, hallucinations, debility and the need for twenty four hour care. Also mentioned were concerns about Resident #14's wife's health and the ability to care for herself. The physician had contacted a service agency himself about in home resources and had	F 250		

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F 250	Continued From page 9 even entertained the possibility of the resident and his wife being admitted together. There was no evidence of any ongoing intervention by social services. In an interview with Social Worker (Employee #5) on 4/14/09, she responded that the spouse had not approached her with any concerns or a desire to be placed outside of her home. There was no evidence that social services was aware of the physician's concerns or of the wife's physical status. Resident #11 was a 78 year old male with the primary diagnoses of arteriosclerotic cardiovascular disease, prostate and bladder cancer, peripheral vascular disease, chronic obstructive pulmonary disease and dementia. He had resided at the facility since January of 2007. His previous cognitive status was that of modified independence. He had no advance directives or power of attorney. He had not been deemed incompetent. He was his own responsible party. He was a full code as of December, 2008. In December 2008, Resident #11 required hospitalization. Upon his return to the facility on 1/7/09, his cognitive functioning had deteriorated. At that time it was not identified if this was temporary or permanent. Resident #11 was not able to make his desires for any code status or advanced directives known. A social work assessment and history completed on 1/11/09, revealed a son and daughter was identified as the only family. This assessment also indicated that Resident #11 had requested to be a full code on his prior admission; but during this assessment, Resident #11 was not able to	F 250		

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F 250	Continued From page 10 participate in a conversation regarding his code status. Review of the clinical record revealed that on 3/27/09, Resident #11 was able to demonstrate his understanding of his code status to a social worker (Employee #5) At this time, Resident #11 told this social worker that he wanted to be a full code. The social worker documented that Resident #11's reply was, "If there was a chance for one more breath, I want it. I am not afraid to live." There was no evidence that this social worker offered Resident #11 to put these desires into writing, specifically creating an advanced directive or living will. An interview with the social worker (Employee #5) at approximately 1:30 PM on 4/10/09, revealed she did not ask Resident #11 if he wanted to prepare any Advance Directives. The social worker stated, "(Resident #11) didn't ask to prepare any Advance Directives. Besides, I feel uncomfortable discussing advance directives with the residents." Employee #5 also confirmed that to create Advance Directives, these legal documents needed to be notarized, because facility staff were not allowed to be witnesses. Employee #5 said there was a $35.00 cost for the notary. Employee #5 denied any knowledge of the free legal aid available to seniors. Employee #5 acknowledged she felt that residents needed to request her assistance for meeting social service needs. She stated, "I'll give them information if they ask for it." Employee #5 also could not demonstrate where to find an identified power of attorney for health care on the Resident's demographic information. An interview with another social worker	F 250		

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F 250	Continued From page 11 (Employee #12) on 4/14/09, revealed the assistance with assisting with resident education of and assistance preparing Advance Directives was part of the social service department. Employee #12 revealed she carried these forms with her, to assist residents with questions and understanding. Employee #12 acknowledged the social service department was a team. There were to be a social worker for each hall and if one individual felt uncomfortable discussing an issue with a resident, they could ask for assistance from another social worker. Employee #12 also acknowledged awareness of the legal aid available to seniors. When asked when discharge planning was to be initiated, Employee #12 confirmed it should be started on admission	F 250		
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide medications, notification of physician regarding refusal of medications and delay in starting antibiotics, and transcription in a change in route in the medication administration record for 1 of 27 sampled residents (#15) and 4 of 6 unsampled residents (#30, #31, #32, #33). Findings include:	F 309	F 309 This facility does and will continue to provide medication as ordered in a timely manner by the correct route and notify the physician of refusals or delays. • Residents # 30, #31, and # 15 no longer reside at the facility. Resident # 32 is receiving medication as ordered. • Residents receiving medications have the potential to be affected and those at risk will be mitigated through adherence to the reorder process.	5-14-09

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F 309	Continued From page 12 MEDICATION AVAILABILITY During the medication pass observed at approximately 8:30 AM on 4/13/09, on the Kensington Unit, it was noted that two residents (unsampled residents #30 and #31) did not have their medications available for administration. One medication, Renal Vit, one to be given daily, had been ordered on 4/3/09. On the day of the medication pass, 4/13/09, unsampled Resident #30 had yet to receive the medication. There was no evidence that any of the medication nurses had attempted to see why the medication was not available. In an interview with the ADON on 4/14/09, she agreed that no queries had been sent to the pharmacy in an attempt to obtain the ordered medication. Unsampled Resident #31's medication, Levothyroxine, was also not available for administration. It appeared that a last dose had been given without a new order having been placed. This resident had also been receiving Prednisone 10 milligrams (mg) every day since 2/25/09. In parenthesis beside the medication, for the last two months of recaps, was the notation "no duration?". However, there was no evidence that any attempt had been made nor had the physician been notified to verify that the Prednisone should continue to be given. In an interview with the medication nurse, she relayed that the procedure is to reorder a medication when they are only five doses of the existing supply remaining. She also indicated that this was not always done.	F 309	• When there are 5 days remaining in the residents supply, the medication will be re-ordered per protocol. Orders for new medications will be processed promptly and Pharmacy delivery discrepancies will be reported to the Director of Nursing or designee. Licensed nurses have been re-educated to the Medication ordering process, the Medication delivery process, reporting of unavailable medications and notification of physician following a resident's refusal of an ordered medication. Licensed staff have also been re-educated to physician order transcription accuracy. • The Director of Nursing or designee will complete random audits of Medication Administration Records and transcription of new medication orders. These audits will occur weekly x4 weeks and then monthly to monitor compliance. Any discrepancies noted will be reported to the Director of Nursing and reviewed by the QAA committee quarterly for further recommendations,	5-26-09

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F 309	Continued From page 13 MEDICATION NOT PROVIDED TIMELY Unsampled Resident #32's physician prescribed Amoxicillin 500 milligrams (mg) to be given three times a day for seven days on the afternoon of 4/7/09, following lab work indicating this resident had a urinary track infection. The facility schedule for three times a day medications was 9:00 AM, 2:00 PM and 8:00 PM. Review of the medication administration record (MAR) revealed that the medication was not started until the morning of 4/8/09. There was no documentation in the progress notes, or a changed physician order to demonstrate the physician was aware the medication could not be given until the following morning. Interviews with two LPN nurse supervisors (Employee #7 and #11) conducted on 4/13/09, confirmed that medications were to be administered within four hours after the order was received, definitely at the 8:00 PM dose. The facility has a medication storage unit (PIXUS) which allowed medication to be available. Employee #11 also confirmed that a local pharmacy was also available if the medication was not located in the PIXUS. A random inquiry conducted by Employee #7 to a floor nurse at this time, also confirmed the floor nurse was aware of the four hour time interval between the received order and the administration of a medication, unless otherwise specified. During the medication pass observed at approximately 8:30 AM on 4/13/09, on the Wellington Unit, it was noted that unsampled Resident #33 did not have two medications available for administration. The medication	F 309		

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F 309	Continued From page 14 Prilosec 20 mg was to be given daily and Baclofen 10 mg was to be given three time a day. When LPN # 11, went to administer the medications, the unit dose paging for unsampled Resident #33's Prilosec and Baclofen was empty. The LPN was then observed going to obtain the medications from the facility's emergency supply from the Pyxis, but neither medication was available. The LPN was then observed calling the pharmacy to reorder the Prilosec and Baclofen, followed by notification to the physician of the missed dose. In an interview with LPN #11, the LPN indicated that the medication should have been reordered when there were only five remaining dose and in calling the pharmacy she had confirmed that the medications had not been ordered. The LPN conveyed that the Prilosec and Baclofen would not be delivered till the afternoon, around or after 1:00 PM. PHYSICIAN NOTIFICATION Resident #15 was admitted to the facility on 12/27/08 with diagnoses that included chronic obstructive pulmonary disease, Type II diabetes, dementia, hypertension, chronic kidney disease, and depressive disorder. His minimum data set (MDS) dated 3/19/09 indicated he had moderately impaired cognitive skills. Medication orders included Furosemide 40 milligrams (mg) tablet once a day, Hydroxychloroquine sulfate 200 mg tablet once daily, Prednisone 10 mg tablet once daily, Digoxin 250 micrograms (mcg) tablet once daily, Systane 0.3% drops, 2 drops four times daily, Zyprexa 10 mg tablet once daily, Combivent inhaler 18-103	F 309		

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F 309	Continued From page 15 mcg two puffs daily, Omeprazole 20 mg capsule once daily, aspirin chew 81 mg tablet once daily, Docusate SOD 100 mg, Fluoxetine HCL 20 mg capsule once daily, KLC 20 mcg liquid once daily, Ativan 0.5 mg liquid twice daily, and Haldol 1 mg liquid twice daily. On 4/15/09, review of Resident #15's Medication Administration Record (MAR) revealed that all of the aforementioned medications were refused by the resident for at least one day between 4/11/09 and 4/15/09. Ten of these medications were refused for all four days during this period. There was no documentation in the resident's record that the resident's physician had been notified of the refusals. On 4/16/09 at 9:30 AM, an interview with the facility's medical director was conducted. He reported that he had not been informed that Resident #15 had refused his medications. He further indicated that the facility's policy was for nursing staff to inform the physician on duty of any refusals by a resident by the day after the refusal. An interview with the nurse unit manager (Employee #7) was conducted on 4/16/09 at 9:45 AM. She concurred with the medical director, that the nursing staff should have informed the facility's physician that Resident #15 refused his medications. Resident #15's MAR was reviewed on 4/15/09. Orders for Ativan and Haldol, prescribed by the facility's medical director on 4/8/09, had been added to the MAR on 4/9/09. The following instructions were listed: "Ativan 0.5 mg SL/PO (sublingual/by mouth) twice daily (liquid)"; "Haldol 1 mg SL/PO (sublingual/by mouth) twice daily (liquid)." The resident's record included a 4/9/09	F 309		

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F 309	Continued From page 16 fax from the resident's hospice physician regarding a modified order for Ativan and Haldol. The order specified that the route of administration for Ativan and Haldol should be changed from PO to SL on 4/8/09. The MAR did not reflect this updated order. An interview with the facility's medical director was conducted on 4/16/09 at 9:30 AM. He confirmed that Resident #15's MAR should have been changed to only indicate the SL route of administration for Ativan and Haldol, as prescribed by the hospice physician.	F 309		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviewed, the facility failed to ensure that each resident received adequate supervision to prevent accidents. (#5 and 28) Findings include: On the morning of 4/14/09, this surveyor was observing the breakfast meal in the Wellington Unit dining room when a scream from the hallway was heard. Upon coming out of the dining room, Resident #28 was observed popping Resident #5's wheelchair up in the air, Resident #5 was in the wheelchair at the time and was observed	F 323	F 323 This facility does and will continue to ensure that the environment remains as free of accident hazards as possible and each resident receives adequate supervision to prevent accidents. • Residents # 7 and 28 were re-educated on safety. Social Services notified of residents behavior. • Behavior tracking/monitoring was initiated and approach included on the residents care plans. Staff educated on resident safety and accident prevention. Assistance required in wheelchair mobility will be provided by facility staff. • There are no other like residents residing in the facility at this time. If the issue presents itself in the future, the issue will be identified and approaches implemented.	4-16-09

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F 323	Continued From page 17 smiling while letting out a scream. The hallway was congested with approximately ten or more other residents who were also in their wheelchairs right next to, as well as adjacent to Resident #28 and #5. In addition, there were several ambulatory residents and visitors in the immediate area. Licensed Practical Nurse (LPN) (Employee #14), was observed coming out of a resident's room at the time of the incident, the LPN looked over at Residents #28 and #5, then looked at this surveyor and stated, "Oh, he's her boyfriend." The LPN was then observed going down the hall to the medication cart where she continued with passing medications. This surveyor continue to observe the situation for approximately five more minutes. Resident #28 was in a hurry trying to get himself and Resident #5 past the congestion to go up the hallway, without staff intervention, within minutes Resident #28 along with Resident #5 were on their way without further incident. Each day of the survey (4/9-4/16/09), Resident #28 was observed on multiple occasions rapidly propelling himself in his wheelchair about the facility. Resident #28 was also observed on multiple occasions while propelling himself in his wheelchair simultaneously propelling Resident #5 ahead of him while she was in her wheelchair. On 4/15/09, LPN # 14, reported to this surveyor that she had completed a report for the 4/14/09 incident involving Resident #28 and #5. The LPN indicated Resident #28 was put on behavior monitoring and that the resident was upset that some had reported him. On 4/16/09, at approximately 8:35 AM, Resident #28 was observed propelling Resident #5 ahead	F 323	• The behavior monitoring will be monitored by the Director of Nursing or designee. Problems identified will be referred to Social Service for additional behavior interventions	5-26-09

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F 323	Continued From page 18 of him and running Resident #5 into a food cart outside the assisted feeding dinning room on the Wellington Unit. On 4/16/09 at 8:45 AM, Certified Nursing Assistant (CNA)(Employee #16) was interviewed. The CNA indicated she had worked at the facility for a year and five months and that within approximately a two month period had observed Resident #28 while in his wheelchair pushing Resident #5 in her wheelchair coming around and hitting the corner of the wall with Resident #5. The CNA indicated she has observed several episodes of Resident #28 popping the wheelchair up in the air with Resident #5 in the chair and that the resident liked it. The CNA indicated that Resident #28 usually does an adequate job of propelling Resident #5, that she didn't think that anyone had ever gotten hurt and that Resident #5 was capable of propelling herself in her wheelchair. On 4/16/09, at approximately 9:10 AM, LPN #15 was interviewed. The LPN indicated she had been the nurse that had started the behavior monitoring on Resident #28 following the 4/14/09 incident and that she had had separate discussions with Residents #28 and #5 regarding safety. The LPN indicated that both parties acknowledged the safety concerns. On 4/16/09, review of Resident #28's medical record revealed a behavior monitoring worksheet which identified "reckless behavior.....while pushing girlfriend in wheelchair playfully and recklessly in hallway." The records failed to reveal a care plan addressing behavior monitoring, or that the issue had been brought to social services attention.	F 323		

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F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334	F 334 This facility does and will continue to screen and provide residents with the opportunity to be immunized for flu and pneumonia. • Residents #1, # 17, # 18, # 13 no longer reside at the facility. Pneumonia screening for Residents # 2, # 3, #14, #10, #21 and #22 have been completed and consent obtained. • The audit of appropriate documentation for residents residing in facility has been completed. • Screening for flu and pneumonia immunization will be completed upon admission and annually thereafter. Licensed nurses will be re-educated to the flu and pneumonia immunization process. • Random audits will be completed by the Director of Nursing or designee. Trends identified will be reported to the QAA committee for further recommendations.	5-14-09 5-26-09

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F 334	Continued From page 20 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review, policy review and staff interview, the facility failed to properly utilize the facility's screening document for pneumovax and influenza vaccinations, therefore not ensuring that 10 of 27 residents received the opportunity for the proper vaccination. (#1, #2, #3, #14, #17, #18, #10, #13, #21, and #22). Findings include: Review of the medical record for Resident #1	F 334		

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F 334	Continued From page 21 revealed that the facility's Patient informed Consent for the Pneumonia Vaccine was signed by the resident, but did not indicate whether the resident agreed to have the vaccination or declined the vaccination. Resident #2's Pneumococcal Vaccination Screening from the facility had none of the screening information completed. The form then indicated that the resident declined the pneumococcal vaccination, but the form lacked the resident or his representative's signature. Review of the medical records for Resident #3 disclosed that neither of the facility forms for Pneumococcal or Influenza vaccinations had been completed. There was no indication if the resident wished to have the vaccinations or not. Resident #14's Pneumococcal Vaccination form revealed that the resident declined the vaccination, but the screening data had not been completed. The Pneumococcal Vaccination Screening form for Resident #17 contained a notation that the resident was not a candidate, however the screening had not been completed as to why he was not a candidate. The form also documented a declination of the vaccine by the resident, presenting conflicting information. While Resident #18 declined to have the vaccination for pneumonia, the screening part of the form was not completed. In an interview with the ADON on 4/14/09, she concurred that staff had failed to properly utilize the forms for pneumonia and influenza	F 334		

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F 334	Continued From page 22 vaccinations. Review of the facility's policy on Infection Control indicated that the immunization guidelines included the process to screen patients and that the screening process identified contraindications, recommendations for administering the second vaccine for the pneumococcal vaccine, and reasons for refusal. Resident #10 refused both the influenza and pneumococcal vaccines on 1/10/09, but this information was not transcribed onto the resident immunization record form. Resident #13 had refusals of both the influenza and pneumococcal vaccines dated 3/30/09, but this information was not transcribed onto the resident immunization record form. The consent forms allowed a choice of four reasons for refusing the pneumococcal vaccine. These choices were 1) Believes not at risk, 2) Believes the vaccine would not work, 3) Afraid of adverse effects and 4) Other, which included a space to fill in the reason the refusal was made. The selection "other" was chosen, but there was no rational listed for the refusal. Resident #21 signed refusals of for the influenza vaccines on 3/10/09, and pneumococcal vaccine (not dated), and this information was not transcribed onto the resident immunization record form. Resident #22 signed refusals of both the influenza and pneumococcal vaccines on 3/9/09, but this information was not transcribed onto the resident immunization record form. In addition, Resident #3, Resident #14, Resident #17 and Resident #18's immunization records	F 334		

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F 334	Continued From page 23 only indicated that their influenza and pneumococcal vaccines had been received prior to admission, no specific dates.	F 334		
F 353 SS=B	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure staff provided feeding assistance to residents in a timely manner. Findings include: Breakfast service was observed on 4/13/09, in the Wellington assisted dining room. At 8:50 AM, five	F 353	F 353 This facility does and will continue to ensure staff provide feeding assistance in a timely manner. • Staffing pattern reviewed for the Wellington dining room and staffing pattern revised to provide for timely assistance for those residents requiring assistance. • Residents requiring assistance with feeding have the potential to be affected • A licensed nurse or supervisor will monitor the Wellington dining room and adjust staffing assignments to ensure sufficient staff is present to provide assistance with feeding in a timely manner. • The Director of Nursing or designee will conduct random observations during meal times to ensure residents are assisted with their meals in a timely manner. Problems identified will be reviewed by the QAA committee for further recommendations.	5-14-09 5-26-09

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F 353	Continued From page 24 Certified Nursing Assistants (CNAs) distributed the meals to the 36 residents seated in the room. Twenty-eight resident were unable to feed themselves. It was observed that five residents waited over 20 minutes (and one resident 45 minutes) before they were assisted with their meals. The nurse supervising the dining room (Employee #6) was interviewed at 10:00 AM. She stated, "Almost all in this dining room need assistance. My expectation is that everyone will eat within 20 minutes, but it's not possible without the full CNAs. It'd be a lot better with six." The CNA responsible for assisting the resident who had waited for 45 minutes was interviewed at 9:55 AM. She had been observed helping to feed two other residents before assisting this third resident. This CNA (Employee #9) stated, "I can only help two at a time. It shouldn't be like this." On 4/14/09 breakfast service was again observed in the assisted dining room. There were four CNAs available to assist 36 residents. After the trays were placed on the tables, it was observed that six residents waited over 20 minutes before being assisted with their breakfast meals. Employee #6 reported she did not know why more CNAs weren't available to help in the dining room.	F 353		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 This facility does and will continue to maintain sanitary conditions for storing and distributing food. • Thorough cleaning of the kitchen was completed, including the floor of the dry storage area, steam table cabinet, stove area and juice dispensing guns and ice machines. Pest control contractor conducted an inspection, and appropriate treatment utilized to eradicate any pests.	4-16-09

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and document review, the facility did not maintain sanitary conditions for storing and distributing food. Findings include: The environmental health specialist conducted an inspection of the facility's kitchen on 4/10/09, and the following findings were listed on his Food Service Inspection Report: 1) Soiling of the following items/areas: dry storage floor, steam table cabinet, stove area, and juice dispensing guns. 2) Two live roaches in the cabinet under the steam table. 3) Damaged items/areas, including the dish table/wall juncture, door gasket of upright refrigerator, wall edge between the dish area and office, base coverings on both sides of the dish area, and cereal cabinet surfaces. An inspection of the facility's food service operations by the survey team's dietitian on 4/13/09 further revealed the following: Sanitation: There was soiling on the upper interior surface of the ice machine in the Wellington nourishment room. In the main kitchen, it was observed that dishes were being rinsed at the food preparation sink, where produce was washed. The food service director indicated that staff kept the food preparation sink clean by washing it with hot water. However, he confirmed	F 371	Repairs have been made on the damaged areas including the dish table/wall juncture, door gasket of upright refrigerator, wall edge and base coverings. Cereal cabinet was replaced with a plastic surface. • Areas of the kitchen have the potential to be affected • The Food Service Manager has re-inserviced the dietary staff on cleaning standards, sanitation and proper labeling and dating of food. The FSM will re-inservice dietary staff on proper dishwashing and food handling procedures. Food will be labeled and dated when prepared and discarded three days after preparation. Dietary and Nursing will be inserviced on these changes. The Maintenance Director will inspect the kitchen and ice machines for necessary repairs on a daily basis. The pest control contractor will re-inspect on bi-weekly basis for the next six months.	5-26-09

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	295043	A. BUILDING _____ B. WING _____	04/16/2009

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F 371	Continued From page 26 that the temperature of the water was not being monitored, and that a sanitizing solution was not being used after dishes were rinsed and before produce was washed. Potentially hazardous foods: It was observed that prepared, refrigerated foods were labeled with a discard date but not a preparation date. One of the facility's dietitians (Employee #8) reported that the kitchen had changed its food dating system in February to reflect an expiration date rather than a preparation date. Note: This new method of date marking did not meet the state regulation requiring that potentially hazardous foods be labeled with the date of opening or preparation.	F 371	• The FSM will inspect the kitchen daily to ensure the cleaning is completed according to standards and schedules and report observations to the Administrator. The Maintenance Director has initiated a repair log for the kitchen. The RD will continue to provide kitchen inspections monthly alerting the FSM and Administrator to areas of concern and recommendations for improvement. The Administrator will conduct random rounds in the kitchen to ensure compliance with follow-up as needed.	
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	F 431 This facility does and will continue to ensure safe and proper storage of drugs and biologicals and disposal of outdated medication. • Medication rooms and medication carts have been inspected and are free of outdated medications and phlebotomy supplies. • Medication rooms and carts have the potential to be affected. These rooms and carts will continue to be inspected on an ongoing random schedule to ensure continued safe storage and absence of outdated drugs. • Licensed nurses have been re-educated to proper labeling and dating when a multiple dose vial is opened.	5-14-09

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F 431	Continued From page 27 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Observation of the medication room refrigerator on the Stratford/Rehab wing on 4/13/09, revealed an open and undated bottle of Mantoux tuberculosis skin test. Interviews with the three licensed practical nurses on this wing confirmed all multi-dose vials were required to be dated when they were open. They also confirmed that Mantoux tuberculosis skin test needed to be discarded 30 days after opening, regardless of how many times it was accessed. Based on observation and staff interview, the facility failed to ensure safe and proper storage of drugs and biologicals and disposal of outdated medications. Findings include: On 4/13/09, an observation of the Team Two's medication cart for the Wellington Unit was made and the following was found: 1) A bottle of Ranitidine tablets that had expired 1/2009. 2) A house stock bottle of liquid Anti-Diarrheal	F 431	• Random inspections of the medication rooms and med carts will be conducted by the Director of Nursing or designee. The Pharmacy Consultant will also inspect the med rooms and carts on a random basis. Issues identified will be corrected immediately, corrective action implemented and results reported to the QAA on at least a quarterly basis.	5-26-09

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F 431	Continued From page 28 that had expired 12/2008. 3) A house stock bottle of Zinc that had expired 8/2008. 4) A house stock bottle of Senna Plus that had expired 1/2009. 5) A house stock bottle of Vitamin C that had expired 5/2008. 6) One bottle of prescription Dilantin Suspension that was opened, not dated, pharmacy label did not have expiration date. 7) Six various sizes, colors and unidentifiable tablets lying loose in bottom of the drawer. Several drawers had a powder residue and needed to be cleaned. Immediately following the medication cart observations, a registered nurse (RN) (Employee #17), was interviewed and acknowledged the medication cart findings. The RN indicated that the prescription Valproic Acid that was opened and not dated had previously been discontinued, changed to a tablet form for the resident and should have been discarded. On 4/13/09, an observation of the medication room for Wellington Unit was made and the following was found: 1) One bottle of house stock Stool Softener that had expired 12/2008. 2) Several un-packaged Phenergan suppositories were found loosely in the med room refrigerator and were not in prescription containers. 3) Two BD Vacutainers used for blood collection that had expired 1/2008. 4) Twenty two BD Vacutainers containing buffering agent used for blood collection that had	F 431		

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F 431	Continued From page 29 expired 3/2009. Immediately following the medication room observations, the Wellington Unit Coordinator, licensed practical nurse (LPN) #7 was interviewed and acknowledged the medication room findings.	F 431		
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on facility policies, staff interviews and clinical record reviews, the facility failed to to ensure residents were properly screened for tuberculosis on admission and yearly for 81 of 176 residents, which includes 7 sampled residents (#7, #8, #9, #12, #15, #16, #24), and two closed resident records (#25, #26). Findings include: The facility used an immunization record form which was located with the individual resident's medication administration record (MAR). This form included areas specific for the 1st and 2nd step recording, as well as influenza, pneumococcal and tetanus vaccine	F 441	F 441 This facility does and will continue to ensure all residents receive TB screening upon admission and annually thereafter. • A complete facility audit was conducted on 4/13 identifying all residents current PPD status. • Testing was initiated for all resident's that could not be accurately identified as to their last PPD test and result. Residents admitted to the facility will have PPD testing per regulatory requirements and facility process. • The facility practice was changed to reflect that all PPD's due for the current month will be administered by the end of the first week of each month. This will ensure compliance with the 364 day cut-off for re-screening. The MAR (Medication administration record) will reflect computer generated monthly updates starting in June 2009 to reflect the month each resident will be due for their annual PPD screening. Education was provided to Licensed nursing staff on the correct method of documenting results of the PPD, utilizing only the 0.00 mm. system. Re-education was conducted on the requirement of patient screening for TB within 24 hour after admission.	4-16-09

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F 441	Continued From page 30 documentation. Interviews with the Director of Nursing (DON) and the Assistant Director of Nurses (ADON) on 4/13-14/09, confirmed that it was the responsibility of the medication nurses to review the immunization record on a regular basis and to administer the Tuberculin Skin Tests (TST) or other vaccines when they were due. The DON and ADON confirmed staff did not document when these TST or vaccines were administered on the monthly MAR. Review of the immunization records of the current 176 residents revealed 74 residents of the residents had not received their Step-1 and/or Step-2 Tuberculin Skin Test (TST) or had them read promptly as described by policy. Review of the clinical records of seven sample residents (#7, #8, #9, #12, #15, #16, and #24) revealed they either never received initial TST or went for periods of two years or longer between annual testing. Review of two closed records revealed the following: Resident # 25 was admitted on 1/6/09, and discharged to another facility on 2/16/09. The immunization record revealed the initial Step-1 was given on 1/7/09. The Step-2 was administered on 2/11/09, but there was no evidence that it was read. There was no evidence of a TST being performed in 2008. Resident #26 was admitted 6/23/07, and expired 1/15/09. The immunization record revealed the initial Step-1 was given on 6/25/07, more than 24	F 441	• Random audits will be conducted by the Nurse Managers. The Nurse Managers will verify the physician order recaps on a monthly basis to ensure the carry over of the PPD month due. The Nurse Managers are responsible to ensure compliance, with DON oversight. Trends will be identified and reported to the QAA committee on a quarterly basis for any further recommendations	5.26.09

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F 441	Continued From page 31 hours after admission. The Step-2 was administered on 7/3/07, but there was no evidence that it was read. There was no evidence of a TST being performed in 2008.	F 441		